

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN5303	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/30/2014
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION -LC		STREET ADDRESS, CITY, STATE, ZIP CODE 1520 GROVE ST BOX 190 LOUDON, TN 37774			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments An annual Licensure survey was completed on January 27, 2014, at Kindred Healthcare and Rehabilitation - Loudon. No deficiencies were cited under chapter 1200-8-6, Standards for Nursing Homes.	N 000			

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

66U611

EXECUTIVE DIRECTOR

2/20/2014

If continuation sheet 1 of 1